Department of Medical Assistance Services
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http://www.dmas.virginia.gov

MEDICAID MEMO

TO: All Commonwealth Coordinated Care (CCC) Plus Waiver Services Providers and CCC Plus Managed Care Organizations (MCOs)

FROM: Jennifer S. Lee, M.D., Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 7/11/2018

SUBJECT: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and CCC Plus Waiver — Effective September 1, 2018

The purpose of this memorandum is to notify providers of upcoming changes to the CCC Plus Waiver. Effective September 1, 2018, individuals under the age of 21, enrolled in the CCC Plus Waiver, must receive personal care, private duty nursing, and assistive technology through the Early Periodic Screening and Diagnostic Treatment (EPSDT) benefit. This change is being made to comply with the Centers for Medicare and Medicaid Services' (CMS) requirement that certain Medicaid funded services for individuals under the age of 21 be accessed through the EPSDT benefit in lieu of a 1915 (c) Home and Community Based Services waiver.

Effective for services beginning on or after **September 1, 2018**, individuals under the age of 21 in the CCC Plus Waiver must receive personal care, private duty nursing, and assistive technology through the EPSDT benefit. Service authorization requests for these services are to be submitted to either the respective Managed Care Organization (MCO) for individuals enrolled in managed care or to KEPRO through the Atrezzo Connect provider portal for Fee-for-Service. The Managed care plans and KEPRO will utilize EPSDT rules and required documentation in authorizing these services.

SERVICE	PROCEDURE CODE CCC Plus Waiver	PROCEDURE CODE EPSDT
Personal Care	T1 T1019 (agency directed)	T1 T1019 (agency directed)
	S5126 (consumer directed)	S5126 (consumer directed)
Private Duty Nursing	T1002 (RN)	S9123 (RN)
	T1003 (LPN)	S9124 (LPN)
	T1000 UI(Congregate RN)	G0493 (Congregate RN)
	T1001 UI (Congregate LPN)	G0494 (Congregate LPN)
Assistive Technology	T5999	T5999

Provider Requirements
EPSDT services shall be approved consistent with requirements specified in the EPSDT policy manual. EPSDT services require that the service be ordered by a physician. Service authorization requests for the services noted above must include the documentation specified below.

EPSDT Assistive Technology:

- Physician's letter of medical necessity;
- Therapist's evaluation report (if signed by a physician, this can serve as the letter of medical necessity);
- A quote from supplier to document provider's wholesale cost or cost description for requests to exceed allowed reimbursement rate; and
- Documentation that this item is not covered by the State Plan, (i.e., Durable Medical Equipment).

EPSDT Personal Care:

- The DMAS 7 EPSDT Personal Care Services Functional Status Assessment (must be updated every year);
- The DMAS 99 Community Based Care Recipient Assessment Report (must be updated every year);
- The DMAS 7A EPSDT Personal Program Agency and Consumer-Directed Plan of Care (must be updated every year): and
- Documentation submitted must include name of the person delivering the service and relationship to the individual.

EPSDT Private Duty Nursing:

- The DMAS 62 Medical Needs Assessment (to be updated and resubmitted every 6 months);
- The current CMS 485 Home Health Certification and Plan of Care; and
- Two weeks of nursing notes (for renewals only).

Reimbursement Rates
There is no change in reimbursement rates.

MAGELLAN BEHAVIORAL HEALTH OF VIRGINIA (Behavioral Health Services Administrator)
Providers of behavioral health services may check member eligibility, claims status, check status, service limits, and service authorizations by visiting www.MagellanHealth.com/Provider. If you have any questions regarding behavioral health services, service authorization, or enrollment and credentialing as a Medicaid behavioral health service provider please contact Magellan Behavioral Health of Virginia toll free at 1-800-424-4046 or by visiting www.magellanofvirginia.com or submitting questions to VAProviderQuestions@MagellanHealth.com.

MANAGED CARE PROGRAMS

Most Medicaid individuals are enrolled in one of the Department's managed care programs: Medallion 3.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan/PACE provider may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the individual's managed care plan/PACE provider directly.

Contact information for managed care plans/PACE providers can be found on the DMAS website for each program as follows:

- Medallion 3.0:
  http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx
- Medallion 4.0:
  http:/www.dmas.virginia.gov/Content_pgs/medallion_4-home.aspx
- Commonwealth Coordinated Care Plus (CCC Plus):
  http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx
- Program of All-Inclusive Care for the Elderly (PACE):
  http://www.dmas.virginia.gov/Content_atchs/ltc/PACE%20Sites%20in%20VA.pdf

COMMONWEALTH COORDINATED CARE PLUS

Commonwealth Coordinated Care Plus is a required managed long-term services and supports program for individuals who are either 65 or older or meet eligibility requirements due to a disability. The program integrates medical, behavioral health, and long-term services and supports into one program and provides care coordination for members. The goal of this coordinated delivery system is to improve access, quality and efficiency. Please visit the website at: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

KEPRO PROVIDER PORTAL

Providers may access service authorization information including status via KEPRO's Provider Portal at http://dmas.kepro.com.

HELPLINE

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

TO ALL MEDICAID PROVIDERS: PROVIDER APPEAL REQUEST FORM NOW AVAILABLE

There is now a form available on the DMAS website to assist providers in filing an appeal with the DMAS Appeals Division. The link to the page is http://www.dmas.virginia.gov/Content_pgs/appeal-home.aspx and the form can be accessed from there by clicking on, "Click here to download a Provider Appeal Request Form." The form is in PDF format and has fillable fields. It can either be filled out online and then printed or downloaded and saved to your business computer. It is designed to save you time and money by assisting you in supplying all of the necessary information to identify your area of concern and the basic facts associated with that concern. Once you complete the form, you can simply print it and attach any supporting documentation you wish, and send to the Appeals Division by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission supported by the Agency.

PROVIDERS: NEW MEDICARE CARDS ARE COMING

CMS is removing Social Security Numbers from Medicare cards to help fight identity theft and safeguard taxpayer dollars. In previous messages, CMS has stated that you must be ready by April 2018 for the change from the Social Security Number based Health Insurance Claim Number to the randomly generated Medicare Beneficiary Identifier (the new Medicare number). Up to now, CMS has referred to this work as the Social Security Number Removal Initiative (SSNRI). Moving forward, CMS will refer to this project as the New Medicare Card.

To help you find information quickly, CMS designed a new homepage linking you to the latest details, including how to talk to your Medicare patients about the new Medicare Card. Bookmark the New Medicare Card homepage and Provider webpage, and visit often, so you have the information you need to be ready by April 1st.

Providers (which includes fee for service, Medicaid Managed Care Organizations, and Commonwealth Coordinated Care Plus) may share the following information with members:

MEMBERS: NEW MEDICARE CARDS ARE COMING

Medicare will mail new Medicare cards between April 2018 and April 2019. Your new card will have a new Medicare Number that is unique to you, instead of your Social Security Number. This will help to protect your identity.

Additional information is available at the following link:
https://www.medicare.gov/forms-help-and-resources/your-medicare-card.html